DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: RBRVS USERS:
Anesthesiologists
Advanced Registered Nurse Practitioners
Ophthalmologists
Psychiatrists
Emergency Physicians
Nurse Anesthetists
Physicians
Physician Clinics
Registered Nurse First Assistants
Family Planning Clinics
Federally Qualified Health Centers
Health Departments
Laboratories
Managed Care Carriers
Podiatrists
Radiologists
Regional Administrators
CSO Administrators

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For Information Contact:
1-800-562-6188

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Subject: **Physician-Related Services (RBRVS) - Year 2002 Changes and Additions to CPT®, HCPCS, and State-Unique Codes**

Effective for claims with dates of service on and after January 1, 2002, the Medical Assistance Administration (MAA) will begin using the Year 2002 CPT® and HCPCS Level II code additions as discussed in this memorandum. Maximum allowable fees for the Year 2002 additions and base anesthesia units (BAU) are also included.

- The attached "Schedule of Year 2002 Procedure Codes and Maximum Allowable Fees" reflect only the new 2002 CPT® maximum allowances, BAU and HCPCS.
- Attached are replacement pages for the July 1, 2001, "Schedule of Procedure Codes and Maximum Allowable Fees," published in the Physicians Related Services Billing Instructions, dated November 2001.
- All procedure code maximum allowable fees and BAU not listed in the fee schedules or in this numbered memorandum remain at the July 1, 2001, level.
- For dates of service after December 31, 2001, do not use deleted state-unique codes, CPT® codes that are deleted in the 2002 CPT® book or HCPCS codes that are deleted in the 2002 HCPCS book.

CPT stands for Current Procedural Terminology
HCPCS stands for Health Care Financing Administration Common Procedure Coding System

Maximum Allowable Fees and BAU

MAA used the following resources in determining the maximum allowable fees and BAU for the Year 2002 additions:

- Year 2002 Medicare Physician Fee Schedule Data Base (MPFSDB) relative value units;
- Year 2002 Washington State Medicare Laboratory Fee Schedule;
- Base anesthesia units established by the Reimbursement Steering Committee; and
- Current conversion factors.

Note: Due to its licensing agreement with the American Medical Association regarding the use of CPT® codes and descriptions, MAA now publishes only the official brief descriptions for all procedure codes. Please refer to your current CPT® book for full descriptions.

Deleted CPT® and HCPCS Codes

The following codes are deleted from the CPT® and HCPCS books:

00850	26585	88170	G0164	J0590	J2480	Q0161
00855	26597	88171	G0165	J0695	J2512	Q2015
00857	29815	93536	G0174	J0730	J2640	Q2016
00884	29909	93607	G0178	J0810	J2675	Q3013
00946	53443	93737	G0184	J1090	J2860	
00955	54402	93738	G0188	J1362	J2970	
01904	54407	A4329	G0190	J1690	J3080	
01906	54409	A5064	G0191	J1739	J3270	
01908	54510	A5074	G0203	J1741	J3390	
01910	80072	A5075	G0205	J1930	J3450	
01912	85095	G0016	G0207	J1970	J7315	
01914	85102	G0126	J0340	J2240	P9042	
01918	85535	G0129	J0400	J2330	Q0144	
01921	86683	G0163	J0510	J2350	Q0160	

Deleted State-Unique Codes

MAA has deleted the following state-unique codes and replaced them with appropriate CPT® or HCPCS codes:

Deleted State-Unique Code	Description	Replacement Procedure Code
5911M	Anesthesia for Vasectomies	00869
5912M	Anesthesia for Sterilizations	00851
5913M	Anesthesia for Hysterectomies	01962, 01963, 00846, or 00944
5914M	Anesthesia for Hysterectomies	01962, 01963, 00846, or 00944
5915M	Anesthesia for Abortions	01964
8999M	Virtual Phenotype, HIV	0023T
9913M	Mirena IUD	J7302

Deleted CPT® and HCPCS Modifiers

The following modifiers are deleted from the CPT® and HCPCS books:

CPT® Modifier	Brief Description
60	Altered Surgical Field
HCPCS Modifier	**Brief Description**
GU	Non fee schedule POS
GX	Non-covered medicare service

New 2002 HCPCS Modifiers

The following new modifiers are added in the 2002 HCPCS book. MAA will accept all of these modifiers as informational only, and neither inclusion nor exclusion of the modifiers will affect payment. Modifier descriptions may be viewed in the 2002 HCPCS book. MAA may require inclusion of some of the modifiers in the future for payment purposes, but will notify providers of such changes at that time.

SA	SE	TE	TJ	GK	GW
SB	SH	TF	GQ	GL	GY
SC	SJ	TG	GB	GM	GZ
SD	TD	TH	GG	GV	KR

Procedures Requiring Written/Fax Prior Authorization

The following new procedures require **written/fax prior authorization**:

Procedure Code	Brief Description
54416	Remv/repl penis contain pros
54417	Remv/repl penis pros, compl
88380	Microdissection
95965	Meg, spontaneous
95966	Meg, evoked, single
95967	Meg, evoked, each addl
0009T	Endometrial cryoablation wit
0010T	Tuberculosis test, cell medi
0012T	Osteochodral knee autograft
0013T	Osteochodral knee allograft
G0231	PET WhBD colorec; gamma cam
G0232	PET WhBD lymphoma; gamma cam
G0233	PET WhBD melanoma; gamma cam
G0234	PET WhBD pulm nod; gamma cam
J2020	Linezolid injection
J2940	Somatrem injection
J2941	Somatropin injection
J7340	Metabolic active D/E tissue
S0093	Morphine 500 mg

To obtain written/fax prior authorization, send your request to:

MAA – Medical Operations
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-2262

Full prior authorization requirements, as well as a fax request form, can be found in Section I of MAA's Physician Related Services Billing Instructions, dated November 2001.

Anesthesia

A. Coding Changes

- The ASA RVG 2001 codes 01961 and 01962 for **nerve block injections** have been deleted and replaced with the ASA RVG 2002 codes in the following table:

ASA Code	Description
02100	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider)
02101	Anesthesia for diagnostic or therapeutic nerve blocks and injections—patient in the prone position (when block or injection is performed by a different provider)

- The 2002 CPT® book includes new descriptions for codes 01961 and 01962, as outlined below:

Procedure Code	Brief Description
01961	Anesthesia, cs delivery
01962	Anesth, emer hysterectomy

- As referenced on page 3 of this numbered memorandum, effective January 1, 2002, state-unique anesthesia codes 5911M – 5915M for **vasectomies, sterilizations, hysterectomies, and abortions** will be discontinued. Use the appropriate new CPT® codes to bill for these services. A valid Sterilization Consent Form (DSHS 13-364x) and/or Hysterectomy Consent Form (DSHS 13-365x) must be attached to the anesthesia claim in order to be reimbursed for these services. Instructions for completing the consent forms and blank copies of the consent forms can be found in Section H of MAA's Physician's Related Services Billing Instructions, dated November 2001.

B. Add-on Anesthesia CPT® Codes 01968 and 01969

CPT® codes 01968 and 01969 are anesthesia add-on codes to be used for cesarean delivery and cesarean hysterectomy following anesthesia given for a planned vaginal delivery. An additional base of 3 is allowed for 01968 and an additional base of 5 is allowed for 01969 in conjunction with the base of 5 for 01967. The time involved with each portion of the procedure should be reported with the appropriate CPT® code. For example, if an epidural anesthetic is given to a client in labor for three hours while a vaginal delivery is still planned, the provider will report 01967 with a total time of 180 minutes. If the provider decides a cesarean section is then necessary, and the cesarean portion of the procedure takes an additional 30 minutes, the provider will report CPT® code 01968 with a total time of 30 minutes on another line on the claim form. The provider will be reimbursed for a grand total of 8 base units and 210 minutes. **MAA reimburses for a maximum of six hours per delivery for anesthesia. However, CPT® code 01969 is excluded from this limitation.**

C. Pain Management Services

MAA has added the following CPT® codes to those that are billable by anesthesiologists for pain management and other services:

- Pain Management: 11981, 11982, 11983, 20526, 20551, 20552, 20553, 64561, and 64581.
- Other Services: 62263, 62287, and 63600.

MAA limits procedures performed for pain management to **two** during the postoperative period while the client is admitted to the hospital. Attached are replacement pages F23 and F24 for MAA's Physician Related Services Billing Instructions, dated November 2001. Those codes in the list identified with an asterisk (*) are subject to this limitation. **Do not use modifier 59 with these codes.** These procedures are paid using the RBRVS methodology, not with anesthesia base and time units. **Do not use anesthesia modifiers when billing for these services**. If an anesthesia modifier is used with one of these codes, the claim will be denied.

Radiology

A. PET Scans

As referenced on page 4 of this memorandum, the following new HCPCS codes for PET scans have been added to those that require written/fax prior authorization:

Procedure Code	Brief Description
G0231	PET WhBD colorec; gamma cam
G0232	PET WhBD lymphoma; gamma cam
G0233	PET WhBD melanoma; gamma cam
G0234	PET WhBD pulm mod; gamm cam

Note: There have been significant changes to the descriptions for **all** HCPCS PET scan codes (HCPCS codes G0030-G0047, G0125, G0210-G0230) from the 2001 HCPCS book to the 2002 HCPCS book. Please note these significant changes in order to insure proper coding of the procedure being performed.

Effective for dates of service on and after January 1, 2002, MAA **will no longer accept the CPT® codes for PET scans** (78608-78609, 78459, 78491-78492, and 78810). You must **use one of the HCPCS codes** from the range G0030-G0047, G0125, and G0210-G0234 when billing for a PET scan. Also, the professional components of all the PET scans will have a **maximum allowable fee of $47.51**. The global and technical components will remain "By Report."

B. Outpatient MRIs

All outpatient MRIs require prior authorization through the Expedited Prior Authorization (EPA) process. The first six digits of the EPA number must be **870000.** The last three digits must be the code number of the diagnostic condition, procedure, or service that meets the EPA criteria. The following chart shows the last three digits appropriate to use for the new MRI procedure:

Procedure Code	Brief Description	Last three digits of EPA Number
76394	MRI for tissue ablation	390

Full EPA requirements can be found in Section I of MAA's Physician-Related Services Billing Instructions, dated November 2001.

C. Contrast Material

MAA will cover the following new HCPCS code established for contrast material at acquisition cost for nuclear medicine procedures:

Procedure Code	Brief Description
A9511	Technetium TC 99m depreotide

D. Professional and Technical Components of Radiology Procedures

In 2001, Center for Medicare and Medicaid Services (CMS – formerly HCFA) deleted the professional (modifier 26) and technical (modifier TC) components of CPT® codes 76000, 93662, and 95824. However, those components have now been restored. Retroactive to dates of service on or after July 1, 2001, the following fees have been established for these components:

Procedure Code	Brief Description	Maximum Allowable Fee Nonfacility and Facility Settings
76000	Fluoroscope examination	$36.08
76000 26	Professional component	$5.38
76000 TC	Technical component	$30.70
93662	Intracardiac ecg (ice)	$181.97
93662 26	Professional Component	$91.66
93662 TC	Technical Component	$90.31
95824	Electroencephalography	$35.41
95824 26	Professional Component	$25.55
95824 TC	Technical Component	$9.86

CMS added professional and technical components to the following radiology procedures:

Procedure Code	Brief Description	Maximum Allowable Fee Nonfacility and Facility Settings
75952	Endovasc repair abdom aorta	B.R.
75952 26	Professional Component	$152.16
75952 TC	Technical Component	B.R.
75953	Abdom aneurysm endovas rpr	B.R.
75953 26	Professional Component	$54.01
75953 TC	Technical Component	B.R.
76012	Percut vertebroplasty fluor	B.R.
76012 26	Professional Component	$44.82
76012 TC	Technical Component	B.R.
76013	Percut vertebroplasty, ct	B.R.
76013 26	Professional Component	$51.32
76013 TC	Technical Component	B.R.

E. Digital Mammography

HCPCS codes G0203, G0205, and G0207 for digital mammograms are discontinued. These codes were used to describe the process in which the film was processed to produce a digital image that was analyzed for potential abnormalities. As an alternative, the new CPT® code 76085 is an add-on code that must be used with CPT® code 76092 to describe this process for screening mammograms.

F. Radiopharmaceutical Diagnostic Imaging Agents

MAA no longer covers CPT® codes 78990 and 79900 for radiopharmaceutical diagnostic imaging agents. Use the appropriate HCPCS code (A4641-A4642; A9500-A9700; and Q3002-Q3012) to bill for these.

Laboratory

A. Stat Lab Codes

None of the new laboratory codes will be added to those that are eligible for an additional stat charge.

B. Fetal Fibronectin

Effective for claims with dates of service on or after January 1, 2002, MAA will begin paying for the lab procedure for fetal fibronectin, CPT® code 82731, at a maximum allowable fee of $64.09.

C. HIV Virtual Phenotype

As referenced on page 3 of this memorandum, state-unique code **8999M** for HIV virtual phenotype is discontinued and replaced with the following HCPCS code:

Procedure Code	Brief Description	Maximum Allowable Fee
0023T	Phenotype drug test, HIV 1	By Report

D. HIV Testing

The CPT® codes for HIV testing 87534, 87535, 87536, 87537, 87538, and 87539 are restricted to ICD-9 diagnoses 042 or V08.

NOTE:
Please remember that laboratory claims must include an appropriate diagnosis code. The ordering provider must give the diagnosis code to the performing laboratory at the time the tests are ordered. MAA will not reimburse a laboratory for procedures without an appropriate diagnosis code.

Family Planning

A. Mirena IUD

As referenced on page 3 of this memorandum, the state-unique code 9913M will be discontinued and replaced with the HCPCS code J7302. The following maximum allowable fee has been established:

Procedure Code	Brief Description	Maximum Allowable Fee
J7302	Levonorgestrel iu contracept	$351.55

B. Contraceptive Rate Changes

The following maximum allowable fees have been established for these contraceptives:

Procedure Code	Brief Description	Maximum Allowable Fee
J1055	Depo-provera, 150 mg	$47.65
1111J	Lunelle monthly injection	$22.99

Maternity Billing Clarification

The following table is included to clarify MAA's limitations regarding billing for prenatal care:

State-Unique Code	Description	Limitations
5951M	Routine antepartum care, first and second trimester, per month	Limited to once per calendar month, per client, per pregnancy; limited to a maximum of six (6) total.
5952M	Routine antepartum care, third trimester, per month	Limited to once per calendar month, per client, per pregnancy; limited to a maximum of three (3) total.
5953M	High-risk management, first trimester, add-on, per month	Limited to once per calendar month, per client, per pregnancy; limited to a maximum of three (3) total.
5954M	High-risk management, second trimester, add-on per month	Limited to once per calendar month, per client, per pregnancy; limited to a maximum of three (3) total.
5955M	High-risk management, third trimester, add-on, per month	Limited to once per calendar month, per client, per pregnancy; limited to a maximum of three (3) total.

☞**Note:** Additional services may be allowed in certain circumstances, such as when the client moves, transfers care to a new provider, etc. In order for MAA to consider payment, providers must indicate the reason for additional services in field 19 of the HCFA-1500 claim form or in the *Comment* field when billing electronically.

Smoking Cessation Counseling For Pregnant Women

Effective for claims with dates of service on and after January 1, 2002, MAA will reimburse eligible providers for including smoking cessation counseling as part of an antepartum care visit or a postpregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination).

Who is eligible for smoking cessation counseling?

Fee-for-service: Tobacco dependent, pregnant women covered under fee-for-service are eligible for smoking cessation counseling. Use this numbered memorandum for billing instructions.

Managed Care: Tobacco dependent women who are enrolled in a managed care organization must have services arranged and referred by their primary care providers (PCP). Clients covered under a managed care organization will have a plan indicator in the HMO column on their Medical Identification card. Do not bill MAA for Smoking Cessation Counseling as it is included in the managed care organizations' reimbursement rate.

Who is eligible to be reimbursed for smoking cessation counseling?

MAA will reimburse the following providers who include smoking cessation counseling as part of an antepartum care visit or a post-pregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination):

- Physicians;
- Physician Assistants (PA) working under the guidance and billing under the provider number of a physician;
- Advanced Registered Nurse Practitioners (ARNP); and
- Licensed Midwives (LM), including certified nurse midwives (CNM).

What is smoking cessation counseling?

Smoking cessation counseling consists of provider information and assistance to help the client stop smoking. Smoking cessation counseling includes the following steps:

- Step 1: Asking the client about her smoking status;
- Step 2: Advising the client to stop smoking;
- Step 3: Assessing the client's willingness to set a quit date;
- Step 4: Assisting the client to stop smoking, which includes a written quit plan. If the provider considers it appropriate for the client, the "assisting" step may also include prescribing smoking cessation pharmacotherapy as needed (see page 13); and
- Step 5: Arranging to track the progress of the client's attempt to stop smoking.

What is covered?

- MAA will allow one smoking cessation counseling session per client, per day, up to 10 sessions per client, per pregnancy. The provider must keep written documentation in the client's file for each session. The documentation must reflect the information listed on page 14.

- MAA covers two levels of counseling. Counseling levels are:

  - ✓ Basic counseling (approximately 15 minutes) which includes Steps 1-3 on previous page; and
  - ✓ Intensive counseling (approximately 30 minutes) which includes Steps 1-5 on previous page.

- Use the most appropriate procedure code from the following chart when billing for smoking cessation.

Procedure Code	Description	Restricted to Diagnoses:	Maximum Allowable	
			Nonfacility Setting	Facility Setting
99401	Preventive counseling, indiv [approximately 15 minutes]	648.43 (antepartum) 648.44 (postpartum)	$23.75	$17.03
99402	Preventive counseling, indiv [approximately 30 minutes]	648.43 (antepartum) 648.44 (postpartum)	$41.68	$34.29

- A provider may prescribe pharmacotherapy for smoking cessation for a client when the provider considers the treatment appropriate for the client. MAA covers certain pharmacotherapy for smoking cessation as follows:

  - ✓ MAA covers Zyban® only;
  - ✓ The product must be prescribed by a physician, ARNP, or physician assistant;
  - ✓ The client for whom the product is prescribed must be 18 years of age or older;
  - ✓ The pharmacy provider must obtain prior authorization from MAA when filling the prescription for pharmacotherapy; and
  - ✓ The prescribing provider must include both of the following on the client's prescription:

    - ➢ The client's estimated or actual delivery date; and
    - ➢ Notation that the client is participating in smoking cessation counseling.

  To obtain prior authorization for Zyban®, pharmacy providers must call:

  Drug Utilization and Review
  1-800-848-2842

From American College of Obstetrics and Gynecologists (ACOG) Educational Bulletin No. 260

Smoking Cessation Intervention for Pregnant Clients

Step 1: ASK–1 minute

- Ask the client to choose the statement that best describes her smoking status:

A. I have NEVER smoked or have smoked LESS THAN 100 cigarettes in my lifetime. ☐

B. I stopped smoking BEFORE I found out I was pregnant, and I am not smoking now. ☐

C. I stopped smoking AFTER I found out I was pregnant, and I am not smoking now. ☐

D. I smoke some now, but I have cut down on the number of cigarettes I smoke SINCE I found out I was pregnant. ☐

E. I smoke regularly now, about the same as BEFORE I found out I was pregnant. ☐

If the client stopped smoking before or after she found out she was pregnant (B or C), reinforce her decision to quit, congratulate her on success in quitting, and encourage her to stay smoke free throughout pregnancy and postpartum.

If client is still smoking (D or E), document smoking status in her medical record, and proceed to Advise, Assess, Assist, and Arrange.

Step 2: ADVISE–1 minute

- Provide clear, strong advice to quit with personalized messages about the benefits of quitting and the impact of smoking and quitting on the woman and fetus. ☐

Step 3: ASSESS-1 minute

- Assess the willingness of the client to attempt to quit within 30 days. ☐

If the client is ready to quit, proceed to Assist.
If the client is not ready, provide information to motivate the client to quit and proceed to Arrange.

Step 4: ASSIST-3 minutes +

- Suggest and encourage the use of problem-solving methods and skills for smoking cessation (eg, identify “trigger” solutions). ☐
- Provide social support as part of the treatment (e.g., “we can help you quit”). ☐
- Arrange social support in the smoker’s environment (e.g., identify “quit buddy” and smoke-free space). ☐
- Provide pregnancy-specific, self-help smoking cessation materials. ☐

Step 5: ARRANGE-1 minute +

- Assess smoking status at subsequent prenatal visits and, if client continues to smoke, encourage cessation. ☐

Data from Melvin C. Dolan Mullen P, Windsor RA, Whiteside HP, Goldenberg RL. Recommended cessation counseling for pregnant women who smoke: a review of the evidence. Tobacco Control 2000; 9:1-5.

Injectable Drug Updates

A. Hyalgan

HCPCS code for **Hyalgan, J7315** is deleted and replaced with HCPCS code **J7316**. Please note, the dosage for this drug will change with the new code description. The following limitations **per knee** apply:

Procedure Code	Brief Description	Maximum Allowable Fee	Restrictions
J7316	Sodium hyaluronate, 5 mg	$33.05 (per unit)	Maximum of 20 units Maximum payment = $661.00

B. Unlisted Drug Codes

MAA no longer reimburses providers for the unlisted drug codes **J8499** and **J8999**.

C. Chemotherapy Drugs

Attached is an updated "Schedule of Maximum Allowable Fees for Chemotherapy Drugs." MAA reimburses chemotherapy drugs at 95% of AWP.

RBRVS Fee Schedule

The RBRVS maximum allowable fees and anesthesiology base units for CPT® and HCPCS codes will be incorporated into the fee schedule and issued when the RBRVS is published, effective July 2002.

To obtain this numbered memorandum and fee schedules electronically go to MAA's website at http://maa.dshs.wa.gov (Provider Publications/Fee Schedules link).